ovacome..
ovarian cancer

Secondary surgery for recurrent ovarian cancer

Ovacome is a national charity providing support and information to anyone affected by ovarian cancer.

We run a free telephone and email support line and work to raise awareness and give a voice to all those affected by ovarian cancer.

This booklet is part of a series giving clinical information about ovarian cancer.

It is for people whose ovarian cancer has recurred and who want to find out more about secondary debulking (also called secondary cytoreductive) surgery.

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Secondary surgery for recurrent ovarian cancer

If your ovarian cancer has recurred, you may have the option of further surgery to remove it. This surgery has various names and may be referred to as secondary cytoreductive surgery, secondary debulking, maximal cytoreductive surgery or ultra-radical surgery.

When your ovarian cancer was first diagnosed it was probably treated with surgery and chemotherapy. Since then, you may have been using a maintenance therapy to control the cancer and keep you well, or you may not have needed this.

Ovarian cancer does often come back, which is called relapse or recurrence.

A recurrence can be treated with chemotherapy and other drugs. Sometimes surgery may be needed to relieve symptoms, for example to remove a cancerous tumour that has spread to the bowel and created a blockage.

What is secondary surgery?

For some people with recurrent ovarian cancer there can be an option of further surgery which aims to remove all the visible cancer. This is secondary cytoreductive surgery that aims to completely remove all the cancer that the surgeon can see.

Secondary reductive surgery should be carried out in expert cancer centres with a specialised and experienced medical and surgical team.

Secondary reductive surgery is now increasingly being performed in the UK. These operations should be carried out in expert cancer centres with a specialised and experienced medical and surgical team. Not all patients with relapsed ovarian cancer will be able to benefit from this surgery. Patients need to meet certain conditions to be considered, to ensure they get the best possible outcome.

How can I access secondary surgery and what do I need to know?

You can ask your consultant or GP to refer you to a larger cancer centre where this surgery is carried out, for a second opinion if it is not available at your treating hospital. This could help you to find out if you would be eligible and whether this type of surgery could benefit you.

At the cancer centre, the specialist team will see and assess you. They will look at your cancer treatment so far and how fit you are.

The team will see where the cancer has come back and how long after your initial diagnosis this happened. They will look at what surgery you have had. Then they will discuss with you whether secondary cytoreduction would be an option.

The specialist team will only discuss secondary cytoreduction with you if they believe that they can remove all the cancer during the operation. Research studies have shown that if this won't be possible, then there is no benefit from operating.

The specialist team will look at your individual circumstances and will carefully consider the risks and benefits for you. Secondary cytoreductive surgery has the best outcomes when it is used in combination with other treatments such as chemotherapy, targeted therapies or anti-hormonal therapies.

Lesley's story

Lesley was diagnosed with stage 3c clear cell ovarian cancer when she was 65.

She had secondary surgery when the cancer recurred one year after she had finished chemotherapy. Her operation in 2013 removed cancer next to major blood vessels. She experienced no postoperative complications.

"My CA125 had gone up to 110 and a scan showed two tumours. The oncologist recommended further chemotherapy and radiotherapy and stated that surgery was very inadvisable.

"I felt in a deep dilemma because the cancer was still in distinct tumours. I had no symptoms, and I would probably never again be in such a good position to consider more surgery. If my timid streak had taken charge I would have backed off and I wouldn't be alive now.
"I knew I had one chance, one window of opportunity and I had to take it.

"My GP supported me and referred me to a different cancer centre for a second opinion. There the consultant said that secondary surgery might be possible – and it was in my best interests to try.

"My family was very supportive, but they thought the surgery was a great risk and that if I opted for more chemotherapy then at least we would all have a few more months together.

"But it was my risk to take – and the surgery was successful."

What are the benefits?

Some research studies have shown that secondary surgery can extend ovarian cancer patients' lives.

Desktop 3 is a randomised clinical trial of 407 women who were given either chemotherapy alone or secondary surgery then chemotherapy. The results were presented in 2020 and showed that secondary surgery, followed by second line chemotherapy, extended survival. But this benefit was only seen when the cancer was completely removed.

Another trial, SOC1, randomly assigned 356 women in their first relapse to either secondary surgery then chemotherapy or chemotherapy alone.

It found that secondary surgery improved progression-free survival at the first recurrence compared to chemotherapy alone. Again, this benefit was only seen in cases where all visible cancer was removed.

However, a third study GOG-0213 of 485 ovarian cancer patients published in 2019, did not show an overall survival benefit for secondary surgery.

But it did show that when compared to using chemotherapy alone, secondary surgery improved progression-free survival (the time after treatment before the cancer starts to grow again) at the first recurrence, in patients where all visible cancer was removed.

Successful secondary surgery depends on identifying the patients most likely to benefit and having a team of specialised and experienced clinicians.

What are the risks?

Secondary surgery includes similar procedures to the first surgery for ovarian cancer. This may include: the stripping of the peritoneum from different sites in your abdomen (peritonectomy), removal of the spleen (splenectomy), bowel resection (removal of part of the bowel) and lymph node resection.

The Desktop study has shown that a stoma is needed in less than 10 per cent (10 in 100) of patients having secondary surgery.

Possible complications of secondary cytoreduction surgery are like those of first debulking surgery.

They are: thrombosis (blood clots), needing further surgery, infection, fluid collections that need to be drained and injury to organs that are close to the cancer.

Research studies have so far shown very low death rates from secondary cytoreductive surgery which is performed by experienced clinical teams with appropriate patient selection.

Clinical guidance

Special guidance on secondary debulking surgery is necessary to ensure safety standards and the best possible outcomes for patients. NICE (National Institute for Health and Care Excellence) states that ultra-radical surgery should be done only within specialised teams trained in extensive surgery. You can see NICE guidance here: https://www.nice.org.uk/guidance/ipg757

NICE states that the operations should be carried out in specialised units where there is regular practice of this type of surgery.(1)

When patients are being asked to consent to the treatment, they must be told about alternative treatment options and about their risks and benefits compared to those of the secondary surgery.

Patients must also be given clear written information about secondary surgery. The British Gynaecological Cancer Society (BGCS) guidance says that the careful consideration of cases within a specialist multidisciplinary team can identify patients who may benefit from further surgery. The criteria would include:

Patients who have relapsed longer than six months from their first-line platinum-based treatment and have no or little ascites at relapse.

Patients should be fit enough for surgery and the specialist team have assessed it is possible for all visible cancer to be removed.(2)

The future

Secondary surgery can work well for a very carefully selected group of ovarian cancer patients. It is part of the progress towards individualised treatment.

More large, specialised centres are needed to train clinicians and provide them with the experience they need so that more people can make this treatment choice.

Researchers continue to look for ways to improve outcomes and benefits for patients with recurrent ovarian cancer.

The use of HIPEC (hyperthermic intraperitoneal chemotherapy) alongside secondary cytoreductive surgery has been investigated. This is the use of a warmed chemotherapy solution to wash through the peritoneal cavity (which contains the intestine, stomach and liver) during the surgery to kill cancer cells the surgeon has not been able to see.

But so far HIPEC has not shown a proven benefit, neither has the use of chemotherapy to shrink the tumour before secondary cytoreduction. Meanwhile, patients need to be more aware of the right to ask for a second opinion within the NHS to explore all their treatment options. You can find out more here: https://www.ovacome.org.uk/getting-a-second-opinion

References

(1.) NICE Maximal cytoreductive surgery for advanced ovarian cancer. Interventional procedures guideline.

(2.) BGCS ovarian, tubal and primary peritoneal cancer guidelines: Recommendations for practice update 2024.

We welcome your feedback on this booklet. Please email ovacome@ovacome.org.uk or call 0800 008 7054. If you would like to discuss anything about ovarian cancer, please phone our support line on 0800 008 7054 Monday to Friday between 10am and 5pm. You can also visit our website at www.ovacome.org.uk. This is one of a series of information booklets produced by Ovacome. You can see them here: ovacome.org.uk/information.

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